Patience PEDIATRICS

Registration Form

Today's Date:				
Patient Information				
Patient Name(s):		**Date of Birth:**	**Age:**	**Sex:**
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Parent Name:	**Cell Phone:**	**Home Phone:**		**Work Phone:**
Parent Name:	**Cell Phone:**	**Home Phone:**		**Work Phone:**
Street Address:		**City/Town:**		**State/ Zip Code:**
Email Address:				
Insurance Information				
Insurance Carrier:		**ID Number:**		
Policy Holder's Name:		**Policy Holder's Date of Birth:**		
In Case of Emergency				
Name of local friend or relative (not living at the same address):		**Relationship:**	**Best Contact Phone Number:**	

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Patience Pediatrics or insurance company to release any information required to process my claims.

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Patient/ Guardian Signature *Date*